Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BODIES IN BALANCE
4151 SOUTHWEST FREEWAY SUITE 210
HOUSTON TX 77027

Carrier's Austin Representative Box
#47

Respondent Name
HARTFORD INS CO OF THE MIDWEST

MFDR Date Received
MAY 4, 2012

MFDR Tracking Number
M4-12-2823-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From Reconsideration Letter Dated December 8, 2011: "Treatment approved by Gerry Gray 972-372-6221, he stated no need for preauthorization, insurance company on the process to change pre authorization departments none assigned to this claim, he will approve reasonable and necessary. Miss Lestra Bell case manager to Bunch and Associates *2084 request pre authorization to be submitted to Bunch and Associates. Pre authorization's submitted Bunch and associates return not processed, no pre authorizations handled by that company since 05/05/11 as per June with Bunch and ASS. Seems that the insurance is going thru a process and we fall on that process, but these services were approved by adjuster Gerry Gray"

Amount in Dispute: $720.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A response was not submitted by the respondent for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 2011	CPT Code 90806	$120.00	$0.00
September 21, 2011		$120.00	$0.00
September 23, 2011		$120.00	$0.00
September 28, 2011		$120.00	$0.00
September 30, 2011		$120.00	$0.00
October 3, 2011		$120.00	$0.00
TOTAL		$720.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated November 10, 2011
   - 197 – Payment adjusted for absence of precert/preauth

   Explanation of benefits dated January 16, 2012
   - 193 – Original payment decision is being maintained
   - 197– Payment adjusted for absence of precert/preauth

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   (A) An emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) Preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(c)(1)(b) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath care listed in subsection (p) of this section was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(7) states "Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

2. Review of the submitted documentation finds no evidence to support that the provider obtained preauthorization for the disputed services prior to providing the health care in dispute. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.